

COLLINGS (S.P.)

Chronic seminal vesiculitis,

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CHRONIC SEMINAL VESICULITIS, WITH HEMORRHAGE.¹

BY

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There has apparently been little known of the pathological conditions of the seminal vesicles until within recent years, and even now there is little written or said about them, although when diseased and incapable of performing their function properly they are capable of making the life of the individual a burden. This is especially true when the inflammation is accompanied with hemorrhage, which is the special phase of the subject I wish to discuss.

ETIOLOGY.

The usual cause of this trouble is the extension of gonorrheal inflammation from the prostatic urethra through the ejaculatory duct into the vesicle itself. At least there is usually a history of a former gonorrhea with a chronic deep urethral trouble remaining. This deep urethral inflammation goes through acute exacerbations from time to time from the use of alcoholic stimulants, sexual excesses or other exciting causes, and gradually the field of inflammation is extended and finally involves the seminal vesicles. This occurs, too, without any apparent warning of their having been implicated, and it is only discovered that they are involved oftentimes by rectal examination. Rarely there are cases, says Dr. Eugene Fuller, of chronic simple vesiculitis caused by sexual excesses and masturbation.

There will be found, as a rule, in these cases which are of gonorrheal origin a urethra that is more or less

distorted and contracted with organic stricture. This results from the chronic inflammatory trouble, and serves at the same time to perpetuate the inflammation. Especially is this true when the membranous urethra is strictured; however, the entire urethra posterior to a tight stricture in any part of the canal, if of long standing, is more or less irritable and inflamed.

These vesicles are sometimes involved in very acute and severe gonorrheal inflammation, with or without the involvement of the cord and epididymis. They may also be involved with a tubercular inflammation, although practically never primarily.

One case has been reported, says Dr. Paul Thorndike, by Soloweitschik, with the autopsy, which undoubtedly involved the vesicle primarily. Also the same author says that Guelliot has collected fourteen cases where the vesicles was the seat of cancer, one of which, reported by Mérricamp, had its origin in the left vesicle.

HISTORY.

The course of most of the subacute or chronic forms of inflammation of these sacs is very similar symptomatically, differing principally in degree of intensity in some one of their manifestations. An exception to this, however, is an accompanying hemorrhage. This occurs only rarely, but may be more or less constant, continuing over a considerable period when it does occur.

The outset of the inflammation is,

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in the subacute or chronic form, very insidious, and its course is obscure so far as direct symptoms are concerned.

In some cases there may be an indefinite burning or itching sensation referred to the region of the prostatic urethra and bladder, or in the rectum; or there may be a feeling of pressure in the perineum. As a rule, when the parts are at rest there is no pain, although there is occasionally a darting pain through this region, which may seem to emanate from the bladder and pass out to the glans penis, or at other times to begin in the prostate and pass up through the bladder to a point above the symphysis pubis. This symptom may be accounted for, I think, by the vesicle becoming over-distended, and in an effort to free itself the muscular walls contract feebly.

A slight contraction of the vesicle wall in an acute inflammation would readily explain the pain, but in the chronic form there is little soreness in the sac, and it is not so easily accounted for. Having only noted this symptom, however, in a chronic case accompanied with hemorrhage, I would account for it by there being at some point in the vesicle an over-sensitive area—perhaps the point of hemorrhage—which was not elicited by palpation.

The general nervous and mental disturbances are at times marked. Following, as they usually do, a protracted gleet, which in itself frequently produces intense nervous disturbances amounting to sexual neurasthenia and accompanied with the sexual disturbances of inflamed vesicles, the mental condition reaches at times almost a state of melancholia.

The urethra is usually hyperesthetic throughout its entire length, which may result in a temporary spasm, interfering with micturition.

The most important symptom is the disturbance of the sexual function. In the majority of cases the disease is accompanied with a decrease in sexual desire, or even in some it may disappear. In the minority, however, says Dr. Fuller, the desire is increased sometimes to such an extent that the craving for intercourse seems to be almost con-

tinuous, but that in these instances little or no gratification or relief is afforded by coitus.

Dr. Zeissl also says that the erections at times amount to priapism. Seminal emissions are often frequent, and there is sometimes left over a feeling of uneasiness and discomfort in the perineal region, with mental depression. This also may follow an ejaculation during coitus. There is usually little or no pain accompanying an emission unless the inflammation be acute.

The character and appearance of the seminal fluid is more or less changed. Its consistency is so increased at times that it is gelatinous. This precludes the possibility of the weakened vesicle walls from entirely expelling their contents, and an over-distention results.

The walls, already weakened by inflammation and constantly distended by the presence of an over-abundance of this gelatinous fluid, are in a condition easily susceptible of the further advancement of the inflammation.

In those due to gonorrhea there is a variable amount of blood, spermatozoa, epithelial and pus cells; the latter much more abundant than in the non-gonorrheal forms.

The appearance and character of the fluid when largely admixed with blood will be discussed in connection with the histories of two selected cases detailed farther on.

DIAGNOSIS.

The diagnosis of subacute or chronic seminal vesiculitis would be difficult to make were we to depend entirely upon symptoms in reaching a conclusion. They are vague and at times misleading, except the appearance of blood in the semen, which, if thoroughly mixed with it, would determine a diseased condition of one or both vesicles at once.

A number of diseases may be easily confounded with the one under consideration, and from which it must be differentiated. Those most easily mistaken for it are: the sexual neuroses, prostatitis, inflammation of the deep urethra, the various bladder disorders,

stricture of the urethra, and spermatorrhea. To determine positively it will generally be necessary to employ the sense of touch.

Dr. Fuller's method of examination is as follows: "The patient presenting himself with a full bladder, should, while standing with his knees straight, bend the body forward at right angles. Then the operator should introduce the forefinger of one hand well into the rectum, the fist of the other hand exercising firm counter-pressure over the pubes. By these means the end of the forefinger will in all ordinary cases reach well beyond the posterior margin of the prostate."

"The swelling is made more evident to the examining finger," says Jordan Lloyd, "when a metal bougie is passed into the bladder and moved from side to side across the tumor."

To empty the vesicle of its contents when found necessary Dr. Fuller further says: "In order to accomplish this, firm pressure is made by the tip of the forefinger on the body of the vesicle as far back as it is possible to reach. The tip of the forefinger is then passed slowly and firmly forward along the line of the vesicle."

Personally, I prefer to have the patient lie on his back on a hard table, for examination, with his thighs flexed to an acute angle with the trunk, allowing the legs to assume their own position against them. In this position the abdominal muscles can be more easily controlled and counter-pressure more effectually made, besides the aid afforded by gravity, and the vesicles, I think, can be more easily reached. The vesicle, if diseased, will usually be found distended and easily felt, though possibly the finger may not reach the entire sac. It will not be found very sensitive to the touch. The retained material may be pressed out into the urethra as described above, and should the patient then urinate the vesicular contents will be found in the urine and can be examined microscopically.

I will now recite briefly the histories of two cases selected as representative types of the chronic form accompanied with hemorrhage.

CASE I.

Aged thirty-one; single; book-keeper by occupation; consulted me on December 31, 1894. He gave a history of having had gonorrhea nineteen months previous, which was his second attack. From this last attack he had never recovered entirely. It involved the deep urethra, and there was a gleet discharge when I first saw him. He had been treated for stricture of the urethra. The meatus and anterior urethra admitted easily a No. 32 bulbous sound; No. 30 detected two quite firm strictures in the bulbo-membranous region, which no doubt had been dilated to that caliber. He complained at times, in urinating, of a delay in starting the stream, or during the act the stream would frequently become small or even dribble away. Accompanying and following urination he had considerable burning pain in the urethra and perineum.

Considering the urethral calibre, it is apparent that the difficulty in urinating was due to a spasm. The patient had masturbated to a considerable extent for a number of years earlier in life, and I am not sure that he had ceased it. The sexual powers were not materially altered, although to some extent weakened.

He complained, without being questioned, of the amount of seminal fluid being less than formerly, and thought "there must be a stricture which held it back."

Unfortunately, the man had syphilophobia and constantly brooded over his troubles, imaginary and real, and kept a vigilant watch over every perceptible symptom.

Upon rectal examination the prostate was found to be perceptibly enlarged and somewhat sensitive to pressure. The right seminal vesicle was distended, but not to a marked degree, and was not very sensitive. The left one was apparently normal.

The distended vesicle was at once emptied of its contents into the urethra, so far as could be done without using undue force, which was immediately subjected to an examination. There

was found a few blood-corpuscles, pus and epithelial cells, and spermatozoa in small numbers, which were lifeless.

He again presented himself on February 25, two months later, and stated that for several days he had noticed a slightly reddish tinge to the last few drops of urine, but which had then ceased. On March 20 this condition returned, and I succeeded in getting a specimen for examination, and found that it contained numerous red blood-corpuscles. Five days later he had an emission which consisted of a dark, tarry mass, composed almost entirely of retained blood. This hemorrhage with the passage of the urine continued, and from time to time the emissions, which were of the same character. They were, however, eventually controlled, and the patient, while I did not consider him entirely well, was nearing complete recovery when he left the city.

CASE II.

Aged twenty-one; single; a cowboy; gave a history of acute gonorrhea nine months previous, which was the third attack, and also developed the secondary eruption of syphilis one month previous to his visit to Hot Springs.

There were no symptoms specially referable to a diseased condition of the seminal vesicles. He came to the Springs to be treated for syphilis, and merely mentioned the fact of his having a little difficulty at times in urinating, and that the last few drops of urine were tinged with blood.

Upon closer questioning I found that he had noticed this blood for two months, and that one month previous he had a night emission, which, to give his own description of it, "consisted of a dark semi-solid mass of a waxy appearance," and that two nights before I saw him another emission which was "thinner and of a brighter red color." This, although he was a man of ordinary intelligence, gave him little or no concern—a marked contrast to Case No I.

The left seminal vesicle was found to be perceptibly distended, and one week later the contents were expressed into the urethra, examined and found to

be as he described. A urethral discharge had continued since his last attack of gonorrhea. The bulbous sound detected strictures at one-quarter inch and three inches from the meatus and in the membranous urethra, admitting respectively Nos. 26, 24 and 23. Posterior to the one in the membranous urethra were some granulations, and possibly may have accounted for a portion of the hemorrhage.

This patient was called away in a short time, and I am not cognizant of the results.

The difference between these two cases is very marked symptomatically, and yet almost identically the same pathological condition existing—the one conspicuous by the varied accompanying symptoms, the other by their absence.

The hemorrhage in these cases was of great interest to me, and I was led to believe that in Case I the hemorrhage came from the ejaculatory duct near the vesicle, and perhaps so in both. The reason is that the blood was of a bright red color, as it would appear just from a ruptured blood-vessel, and no vesicular contents whatever could be found.

It would be reasonable, I think, to expect to find some of the collected stale contents of the vesicle with the fresh blood, but after repeated examinations none was apparent, except when the sac was stripped or when the patient had an emission.

The ducts may have been inflamed as the vesicles were, and there might have been a small hemorrhage from them at each urination, caused by the act, part of the blood flowing out into the prostatic sinus and part entering the vesicle; and, again, it might have come from the "ampulla" or widened portion of the vas deferens near its termination. The seminal vesicles, no doubt, partially but not wholly acting as store houses for the testicular secretion, might receive in the same manner small amounts of blood under slight backward pressure at each urination, and finally become distended with it.

This blood remaining in the vesicles for days or weeks, and being admixed with the vesicular secretion, would undergo the changes noted in the ap-

pearance of the discharges in these two cases.

TREATMENT.

I will discuss briefly the treatment as applied to these cases, and that generally used in the subacute and chronic forms.

The object in treatment is to empty the distended vesicle and allow the muscular walls to regain their tonicity. This is accomplished by the maneuver described above, which need not be repeated here. Under favorable circumstances in the ordinary form, without hemorrhage, this treatment can be given in from five to eight days. As for those with hemorrhage, it is a questionable method to pursue—in fact, it should not be done as a routine practice while there is evidence of hemorrhage to a considerable extent, as in the cases reported.

After the flow of blood has ceased, as evidenced by a close inspection of the urine, the vesicle should be relieved of its contents. Ergotine internally, astringent suppositories and rectal in-

jections of hot water were used to control the hemorrhage in the cases reported. The rectal injections were used twice a day, of water direct from the springs, and as hot as could be borne with comfort.

Had I then been in possession of the rectal psychrophore, devised by Dr. Alfred Wiener, of New York, I believe the results would have been even more satisfactory. While the instrument was devised more especially for the application of cold to the prostate gland, I think it will be of immense value in the treatment of inflammations of the seminal vesicles. I have used it in a case of acute epididymitis with involvement of the seminal vesicles. From the first application there was an immediate improvement, and under its continued use the patient made a very rapid and complete recovery.

Let me say, in conclusion, that if an inflammation of the vesicle occurs in one whose urethra is strictured, cure the stricture before you can hope for permanent results in your vesicle treatment.

